MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13983 13952

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 28
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 610 W. Bel Air Ave.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) — e. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 610 W. Bel Air Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel — Middle: Lee — Last: Baker
4. DATE OF DEATH: Month: 12 — Day: 8 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/13/1882
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Ridgely
14. MOTHER'S MAIDEN NAME: Sarah Ann Jervis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Chas W. Baker - Aberdeen Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 16 mos
DUE TO (b): 151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): generalized arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-23, 19 60, to 12-8, 19 61, that (I) (we) last saw the deceased alive on 12-6- 19 61, and that death occured at 7 A.M., from the causes and on the date stated above.

22a. SIGNATURE: B J Plunkett Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-9-61
22c. PHYSICIAN'S NAME (Type): B.J. Plunkett Jr. M.D.
22d. ADDRESS: 617 W. Bel Air Ave. Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/10/1961
23c. NAME OF CEMETERY OR CREMATORY: Bakers Cemetery
23d. LOCATION (City, town, or county) (State): Aberdeen, Harford Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Tarring Funeral Home Aberdeen. Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 12 '61
25b. REGISTRAR'S SIGNATURE

John G. Tarring

A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13984 — 13953

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USArmy Hospital, Aberdeen Proving Ground

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 28 Aberdeen
d. STREET ADDRESS: 109 H Rodman Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLIFTON — Middle: WILLIAM — Last: BAYNARD JR

4. DATE OF DEATH: Month: DECEMBER — Day: 11 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 July 1956

9. AGE (In years last birthday): 5 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: N/A

11. BIRTHPLACE (County & State, or foreign country): St Alban's, New York

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: CLIFTON W. BAYNARD

14. MOTHER'S MAIDEN NAME: HELEN E. GOWENS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): N/A — (If yes give war or dates of service): N/A

16. SOCIAL SECURITY NO.: N/A

17. INFORMANT — Address: Clifton W. Baynard (Father) Same as Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Wilm's Tumor, left kidney — INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 16 November 1961 to 11 December 1961, that (I) (~~saw~~) last saw the deceased alive on 11 December 1961, and that death occured at 1:45 PM from the causes and on the date stated above.

22a. SIGNATURE: Malcolm McLean M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 11 Dec 61

22c. PHYSICIAN'S NAME (Type): MALCOLM McLEAN, Captain, MC

22d. ADDRESS: US Army Hospital, Aberdeen Proving Ground, Maryland

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial — 23b. DATE THEREOF: 12-16-61 — 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Whitford Cemetery — 23d. LOCATION (City, town or county) (State): Darlington, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: James DeShields — ADDRESS: Fallston, Md.

25a. REC'D BY REGISTRAR DATE: DEC 15 '61 — 25b. REGISTRAR'S SIGNATURE: Chas. S. Krause

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13985 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13954

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit 07x2
d. STREET ADDRESS Center Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Lydia Middle: Irene Last: Brown

4. DATE OF DEATH Month: December Day: 5 Year: 1961

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-26-57

9. AGE (In years last birthday) 4 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Henry E. Brown

14. MOTHER'S MAIDEN NAME: Olethia O. Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Henry E. Brown, Center St., Address: Port Deposit Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture skull
825X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Auto accident

20c. TIME OF INJURY Hour: 5 p.m. Month, Day, Year: 12-5-1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Center Street

20f. (City or town) Port Deposit (County) Cecil (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF M.D. Gerald C Palmer

EXAMINER'S NAME (Type) Gerald C Palmer MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 12-6-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12-9-1961

22c. NAME OF CEMETERY OR CREMATORY Jones Memorial Cem.

22d. LOCATION (City, town, or country) Port Deposit, Md., Rural (State)

23. FUNERAL DIRECTOR Lee A. Patterson & Son

ADDRESS Perryville, Md.

24a. REC'D BY REGISTRAR DATE DEC 11 '61

24b. REGISTRAR'S SIGNATURE Arthur L. Nunn

Items 18-21 Film 305
I-10-62 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13985 13955

1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood
d. STREET ADDRESS: MAIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First DOROTHY Middle ALLISTER ARCHER Last BURTON
4. DATE OF DEATH: Month December Day 30 Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/1/07
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BAR MAID
10b. KIND OF BUSINESS OR INDUSTRY: TAVERN
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 219-34-4846
17. INFORMANT: ALLISTER ARCHER-BURTON Address: MAIN ST EDGEWOOD MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Salicylate Intoxication
970.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Salicylate ingestion
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: 12/30 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Edgewood (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☐. Inquiry ☐. and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☒. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 12/31/61

EXAMINER'S NAME (Type): Charles S. Petty, M.D.
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1/3/62
22c. NAME OF CEMETERY OR CREMATORY: WOODLAWN
22d. LOCATION (City, town, or country) (State): WOODLAWN MD

23. FUNERAL DIRECTOR: Paul E. Chronowith ADDRESS: 345 Chestnut Ave
24a. REC'D BY REGISTRAR DATE: JAN 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13987 — Reg. Dist. No. 13956

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Benson
d. STREET ADDRESS: 1 Harford Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel — Middle: E. — Last: Carl

4. DATE OF DEATH: Month: December — Day: 6, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: January 11, 1886

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William H. McElroy

14. MOTHER'S MAIDEN NAME: Annie McElroy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

17. INFORMANT — Address: G. Herman Carl — Benson, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b):
DUE TO
(c): Chronic cardio-vascular disease — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from November 29, 1961, to December 6, 1961, that I last saw the deceased alive on December 6, 1961, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Maryland — DATE SIGNED: December 7, '61

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — **22b.** DATE THEREOF: 12/11/1961 — **22c.** NAME OF CEMETERY OR CREMATORY: Greenmount — **22d.** LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz — ADDRESS: Parrettsville, Md

24a. REC'D BY REGISTRAR DATE: DEC 11 '61 — **24b.** REGISTRAR'S SIGNATURE: Clifton L. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Forms 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13988 13957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN this place: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): US Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 602 Plater Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (redacted) Vincent-Joseph - COSTA

4. DATE OF DEATH: December 10 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8 December 1961

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months: Days: 2 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not applicable

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (County & State or foreign country): US Army Hospital, Aberdeen Proving Ground, Md

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carmen Frank Costa

14. MOTHER'S MAIDEN NAME: Beulah Ferl Caudill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Carmen F Costa (Father) Address: Same as Item #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Gross prematurity — INTERVAL BETWEEN ONSET AND DEATH: Congenital

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

7766

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8 Dec 61 19.. to 10 Dec 61 19.., that (I) (we) last saw the deceased alive on 10 Dec 61 19.., and that death occured at 9:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Fraher MD M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10 Dec 61

22c. PHYSICIAN'S NAME (Type): THOMAS J FRAHER, MD

22d. ADDRESS: US Army Hospital, Aberdeen Proving Ground, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/13/1961

23c. NAME OF CEMETERY OR CREMATORY: Post Cemetery

23d. LOCATION (City, town or county) (State): Aberdeen Proving Grd. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — **ADDRESS**: aberdeen Maryland

25a. REC'D BY REGISTRAR DATE: DEC 13 '61

25b REGISTRAR'S SIGNATURE: Cinthia S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13989 13958

1. PLACE OF DEATH
a. COUNTY: Harford — Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 520 Market St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carlton — Middle: — Last: Fletcher

4. DATE OF DEATH: Month: 12 — Day: 14 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1916

9. AGE (If years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done for most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Painter

11. BIRTHPLACE (County & State, or foreign country): Havre de Grace Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: C. Frank Fletcher

14. MOTHER'S MAIDEN NAME: Bertha Krause

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Ruth Fletcher — Address: 610 Desago Havre de Grace

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

DUE TO (b): Coronary Thrombosis — 5 minutes

DUE TO (c): Hypocreditis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. I20.1.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): /

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1940 19.., to Dec 14, 1961, that (I) (we) last saw the deceased alive on Dec 14, 1961, and that death occured at 2A M, from the causes and on the date stated above.

22a. SIGNATURE: Frank Wolbert M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Dec 15, 1961

22c. PHYSICIAN'S NAME (Type): FRANK WOLBERT MD — 22d. ADDRESS: HAVRE DE GRACE MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12/17/61 — 23c. NAME OF CEMETERY OR CREMATORY: Grove — 23d. LOCATION (City, town or county) (State): Aberdeen Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Beacom Funeral Home — ADDRESS: Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE DEC 20 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Hirons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13990 Reg. Dist. No. 13959

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pulaski Hyway & Joppa Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Joppa
d. STREET ADDRESS: Pulaski Hyway & Joppa Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Robert — Middle: — Last: Forrester
4. DATE OF DEATH: Month: Dec. — Day: 24 — Year: 1961
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 8, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Forrester
14. MOTHER'S MAIDEN NAME: Ann Tasker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Priscilla Forrester — Address: Pulaski Hwy. Joppa Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 14 hr.
DUE TO (b): Arteriosclerotic CVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct., 1960, to Dec. 21, 1961, that I last saw the deceased alive on Dec. 20, 1961, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William A. Tyson M.D. — ADDRESS (Street, city or town, state): Kingsville, Md. — DATE SIGNED: 12-21-61
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-26-61
22c. NAME OF CEMETERY OR CREMATORY: Community Bapt.Chr.Cem
22d. LOCATION (City, town, or county) (State): Harford, Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: M. Lincoln Hendley — ADDRESS: 578 W. Biddle St.
24a. REGISTRAR: — DATE: 12 21 61
24b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13991 — 13980

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
c. LENGTH OF STAY IN 1b: 3 wks.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Street
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Christine — Last: Freeman

4. DATE OF DEATH: December 20, 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: August 17, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 4 Days: 3 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -----

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (County & State, or foreign country): Havre de Grace, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Estil Freeman

14. MOTHER'S MAIDEN NAME: Louise Combs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): --

16. SOCIAL SECURITY NO.: ---

17. INFORMANT Address: Estil Freeman, Street, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

Prematurity.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Dec 20, 1961 to Dec 20, 1961 that (I) (we) last saw the deceased alive on Dec 20, 1961, and that death occured at 12.30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Jonah A. Hunt M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/21/61

22c. PHYSICIAN'S NAME (Type): Josiah A. Hunt, MD

22d. ADDRESS: Delta Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 22, 196.

23c. NAME OF CEMETERY OR CREMATORY: Fellowship

23d. LOCATION (City, town or county) (State): Pylesville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John H. Watkins

ADDRESS: Delta, Penna.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13992

CERTIFICATE OF DEATH

13961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: R.F.D. 1, Always Inn
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: David — Middle: Lewis — Last: Grace

4. **DATE OF DEATH**: Month: December — Day: 24 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/16/1872

9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: David Grace

14. MOTHER'S MAIDEN NAME: Isabell Minton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: James P. Grace

Address: Street, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4-3X Cerebral Hemorrhage - Left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO (b): Hypertensive and arteriosclerotic Cardiovascular disease — 3-4 years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Terminal pneumonitis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 20th, 1961 to Dec. 24th 1961, that (I) (we) last saw the deceased alive on Dec. 24th, 1961, and that death occured at 8 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D.

M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/24/61

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 12/27/61

23c. NAME OF CEMETERY OR CREMATORY: Oak Grove

23d. LOCATION (City, town or county) (State): Churchville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Thomas Ray, Jr.

ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13993 13962

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.) a. STATE: Md b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 111 S. Bond St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mittie Middle: M. Last: Greer
4. DATE OF DEATH: Month: 12 Day: 11 Year: 1961

5 SEX: F
6 COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: Oct 12 1888
9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Grayson Co Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Linder Cole
14. MOTHER'S MAIDEN NAME: Dorothy Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Geo Greer Address: Bel Air Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Hypertensive Cardiovascular Disease — 3 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Diabetes Mellitus
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Dec 11th 19 — to Dec 11th 1961 that (I) (me) last saw the deceased alive on Dec 11th 1961 and that death occurred at 2:45 P.M. from the causes and on the date stated above

22a SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b DATE SIGNED: 12/11/61
22c PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Dec. 12, 1961 — 23c NAME OF CEMETERY OR CREMATORY: Sparta M. C. — 23d. LOCATION (City, town, or county) (State): Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. S. Bailey Darlington Md
25a. REC'D BY REGISTRAR: DEC 15 '61
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13994

CERTIFICATE OF DEATH

13963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and c...tely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Chester Middle: P Last: Grier

4. **DATE OF DEATH**: Month: 12 Day: 20 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 27, 1882

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSERY MAN

10b. KIND OF BUSINESS OR INDUSTRY: Ret. Nusuryman

11. BIRTHPLACE (County & State or foreign country): Pikesville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Grier

14. MOTHER'S MAIDEN NAME: Mary A. Grier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: MRS SYVILLA H. GRIER FOREST HILL MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH:

420.1

DUE TO (b): Chr Cardiovascular Renal

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 2, 1955 to Dec. 20, 1961, that (I) (we) last saw the deceased alive on Dec 19 1961, and that death occured at 2:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/20/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: FOREST HILL, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12/23/61

23c. NAME OF CEMETERY OR CREMATORY: DEER CREEK

23d. LOCATION (City, town or county) (State): CHESTNUT HILL MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz

ADDRESS: Jarrettsville Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Timus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13995 — 13964

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 16 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1 Box 1

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL HAVRE DE GRACE
d. STREET ADDRESS: R.D. 1 - Box 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	LAURA	BELL	HALL		DEC.	17	1961

5. SEX	6. COLOR OR RACE	7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
FEMALE	WHITE		FEB. 15, 1887	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	HOME	VA.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ELBERT P. ROBERTS	DIANA HALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (Address): ROBERT G. HALL, HAVRE DE GRACE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): 331X — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension - Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not While at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office b dg, etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-1-61, 19..., to 12-5, 1961, that (I) (we) last saw the deceased alive on Dec 5, 1961, and that death occured at 10:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county)	(State)
BURIAL	DEC. 20, 1961	BEL AIR MEMORIAL GARDENS	HARFORD Co	MD.

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD.
25a. REC'D BY REGISTRAR DATE: DEC 20 '61
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ... director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7 61

Item 18 Film 307 2-9-6

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13996

CERTIFICATE OF DEATH

13965

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 15 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
d. STREET ADDRESS: Thomas Bridge Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3 NAME OF DECEASED (Type or print): First: Cameron — Middle: L. — Last: Harkins
4. DATE OF DEATH: Month: 12 — Day: 6 — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: FEB. 11, 1882
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11 BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Thomas Harkins
14 MOTHER'S MAIDEN NAME: Emma Robison

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17 INFORMANT: Address: CLAUDE E. HARKINS, STREET, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Fresh Myocardial infarction	1 day
DUE TO (b)	Coronary thrombosis	1 day.
DUE TO (c)	A. S. C. V. D.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Active pulmonary tuberculosis; Pulmonary infarction, Pneumonitis, Profuse amount of rectal Bleeding from hemorrhoids.

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Nov. 23rd, 1961, to Dec. 6th, 1961, that (I) (we) last saw the deceased alive on Dec. 6th, 1961 and that death occurred at 4:1 M, from the causes and on the date stated above.

22a SIGNATURE: Edward C. Loo, M.D.
ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22b DATE SIGNED: 12/6/61
22c PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 12-9-61
23c. NAME OF CEMETERY OR CREMATORY: EMORY
23d LOCATION (City, town, or county) (State): STREET, HARFORD CO., MD.

24 FUNERAL DIRECTOR'S SIGNATURE: John H. Harkins
ADDRESS: DELTA, PA.
25a RECD BY REGISTRAR DATE: DEC 11 '61
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13997 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13966

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD 2

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Havre de Grace
d. STREET ADDRESS: 1 RD 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Johnny — Middle: George — Last: Hubble

4. DATE OF DEATH: Month: December — Day: 16 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Sept. 20, 1898

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Kent Hubble

14. MOTHER'S MAIDEN NAME: Amamda Victoria Purcell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-05-3402

17. INFORMANT: Lenora R. Hubble, Havre de Grace — Address: R.D. 2-

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive V disease — INTERVAL BETWEEN ONSET AND DEATH:

443X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER [ ] Baltimore

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 12-16-61

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/18/61

22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

22d. LOCATION (City, town, or country) (State): R.D., Bel Air, Maryland

23. FUNERAL DIRECTOR ADDRESS: John G Tarring — Tarring Funeral Home, Aberdeen, Md.

John G. Tarring

24a. REC'D BY REGISTRAR DATE: DEC 21 '61

24b. REGISTRAR'S SIGNATURE: Clara L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13998

CERTIFICATE OF DEATH

Reg. Dist. No. 13967

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Fallston
c. LENGTH OF STAY IN 1b: 9 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Fallston

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Reckord Road
d. STREET ADDRESS: Reckord Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Otto Middle: Walter Last: Hyne

4. DATE OF DEATH: Month: December Day: 2 Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1894

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam Fitter

10b. KIND OF BUSINESS OR INDUSTRY: Shipyard

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Emil Hyne

14. MOTHER'S MAIDEN NAME: Freida Prussia

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-05-0808

17. INFORMANT (Wife): Mrs. Madeline G. Hyne Address: Reckord Road Hydes, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARDIO-RESP FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

204.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CONG. HEART FAILURE - ARS, C.V.D. — 4 Mo.

DUE TO (c): LEUKEMIA. — 1½ YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): INJURIES IN AUTO ACCIDENT - MAY 1961 - BROKEN HIP.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): AUTO COLLISION.

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: MAY 1961

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1949 to NOV. 1961, that I last saw the deceased alive on 1 DEC 1961, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H. P. Sidwell M.D. ADDRESS (Street, city or town, state): 401 Franklin St. Bel Air DATE SIGNED: 4 Dec 61

Derwin E. Palmer M.D. Deputy Health Officer

PHYSICIAN'S NAME (Type): H. P. Sidwell, M.D. Franklin St., Bel Air, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 5, 1961

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or county) (State): Bel Air, Harf., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster ADDRESS: W. Broadway & Williams Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 5 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

FOSTER FUNERAL HOME
W. BROADWAY & WILLIAMS
BEL AIR, MD.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13968

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 6 yrs.,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheel Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air Rural
d. STREET ADDRESS: Wheel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Kyle — Last: Ison

4. DATE OF DEATH: Month: December — Day: 29 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Mar. 22, 1904

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Landscaping

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Thomas L. Ison

14. MOTHER'S MAIDEN NAME: Hattie Thorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 212-32-4368

17. INFORMANT — Address: Mrs. Lillian R. Isom, Bel Air R.D. #3 Md.,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma lung
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163 X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Belair md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 12-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 23, 1961

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, country) (State): Bel Air, Harford, Md.,

23. FUNERAL DIRECTOR: Howard K. Mc Comas & Son — Howard K McComas Jr

ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR — DATE: DEC 26 '61

24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14090 CERTIFICATE OF DEATH

13969
Reg. Dist. No.

1. PLACE OF DEATH
COUNTY Baltimore — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel-Air
LENGTH OF STAY (In this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 137 Aliceanne Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Baltimore
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel-Air
STREET ADDRESS (If rural give location) 137 Aliceanne Street

3. NAME OF DECEASED (Type or Print) (First) ALBERTA (Middle) (Last) JOHNSON

4. DATE OF DEATH (Month) DEC (Day) 4 (Year) 1961

5. SEX F
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH APR 7, 1878
9. AGE last birthday 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Westcoat
14. MOTHER'S MAIDEN NAME Augustus Spriggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. ~~220-30-2127~~
17. INFORMANT & ADDRESS Joseph Johnson-2416 Harlem Ave. Balto., Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
IMMEDIATE CAUSE (A) CARDIO-RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
ANTECEDENT CAUSE(S) DUE TO (B) ADVANCED ARTERIOSCLEROSIS — 4 YEARS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1959, to DEC, 1961, that I last saw the deceased alive on 4 DEC, 1961, and that death occurred at 8:00 P M, from the causes and on the date stated above.

SIGNATURE W. Hadwell M.D.
ADDRESS (Street, city, town, state) 401 Franklin St. Bel Air
DATE SIGNED 4 DEC 61

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 12-8-61
NAME OF CEMETERY OR CREMATORY Henden Hill
LOCATION (City, town, or county) (State) Bel-Air, Md.

24. REC'D BY REGISTRAR
DATE
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR'S SIGNATURE George W. Hill
ADDRESS Bel Air 230

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14001 — 13970

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: MARYLAND 3 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BEL AIR
d. STREET ADDRESS: Fountain Green Heights
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bridget — Middle: M — Last: Johnston

4. DATE OF DEATH: Month: DECEMBER — Day: 21 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 17 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Timothy Brackett

14. MOTHER'S MAIDEN NAME: Mary Connolly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs Joseph Umberger — Address: 304 Lake Side Dr. Bel Air Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia, right lower lobe — Interval between onset and death: 4 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b) A.S.C.V.D.
DUE TO (c) Generalized arteriosclerosis + senility — 2-3 years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 18th., 19 61 to Dec. 21st., 19 61, that (I) (we) last saw the deceased alive on Dec 21st., 19 61, and that death occured at 2:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Edward C Loo M.D.

22b. DATE SIGNED: 12/21/61

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): Edward C Loo M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 12/22/1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery

23d. LOCATION (City, town or county) (State): Kansas City, Mo.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — ADDRESS: Aberdeen, Maryland.

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Carlton L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14002 13971

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 of funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanne de Grace, DOA
   c. LENGTH OF STAY IN 1b
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
   a. STATE: Md
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
   d. STREET ADDRESS: R D 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First IVAN Middle FRANK Last KLATIL

4. DATE OF DEATH: Month December Day 21 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 3, 1935

9. AGE (In years last birthday): 26 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Technician

10b. KIND OF BUSINESS OR INDUSTRY: Electronics

11. BIRTHPLACE (State or foreign country): Czechoslvakia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aldrich Klatil

14. MOTHER'S MAIDEN NAME: Marta Misurcova

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 218-32-6781

17. INFORMANT: Aldrich Klatil, Address R.D. 1 Abingdon, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Fracture skull
- DUE TO (b):
- DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident

20c. TIME OF INJURY Month, Day, Year: Hour 11 a.m. p.m. 12-21 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Edgewood (County) Ha. (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ Belton, Md

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer

Address (Street, city, town, or county)

DATE SIGNED 12-27-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/24/61

22c. NAME OF CEMETERY OR CREMATORY: St Francis Cemetery

22d. LOCATION (City, town, or country) (State): Abingdon, Maryland

23. FUNERAL DIRECTOR: John E. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: DEC 29 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14003

CERTIFICATE OF DEATH

Reg. Dist. No. 13972

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hydes.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisy — Middle: A. — Last: Kolk

4. DATE OF DEATH: Month: December — Day: 24 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-3-1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Washington Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Hoffmaster

14. MOTHER'S MAIDEN NAME: Mary Rohrer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Howard Tolle, Jr. Box 366, Baldwin, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-24, 1961, to 12-24, 1961, that I lost saw the deceased alive on 12-24, 1961, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gerald E Palmer M.D.
ADDRESS (Street, city or town, state): Bel Air, Md.
DATE SIGNED: 12-25-61
PHYSICIAN'S NAME (Type): Gerald E Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/28/1961
22c. NAME OF CEMETERY OR CREMATORY: Fork Methodist Ch. Cem.
22d. LOCATION (City, town, or county) (State): Fork, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H.W. Jenkins & Sons Co.
ADDRESS: 4905 York Road Baltimore 12, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 29 '61

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14004 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 13973

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b About 6 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE N.J. — b. COUNTY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark — 6 ix 2
d. STREET ADDRESS 358 Leslie Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Harvey Middle: — Last: Lehrhoff

4. DATE OF DEATH Month: December Day: 13 Year: 1961

5. SEX M — 6. COLOR OR RACE W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH Jan. 4 - 1944 — 9. AGE (In years last birthday) 17 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours M.n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student — 10b. KIND OF BUSINESS OR INDUSTRY none — 11. BIRTHPLACE (State or foreign country) New Jersey — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Max Lehrhoff — 14. MOTHER'S MAIDEN NAME Rose Horbwitz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No — 16. SOCIAL SECURITY NO — 17. INFORMANT Address: Unknown Hosp Records, Havre de Grace

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture Skull
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident
20c. TIME OF INJURY Hour: 11 a.m. p.m. Month, Day, Year: 12 13 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 215 Route 40
20f. (City or town) Aberdeen (County) Ha (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M D
EXAMINER'S NAME (Type) Gerald C Palmer MD
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED 12-13-61

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF 12/14/61 — 22c. NAME OF CEMETERY OR CREMATORY Beth Israel — 22d. LOCATION (City, town, or country) Woodbridge N.J. (State)

23. FUNERAL DIRECTOR Pennington & Son, Havre de Grace Md. — ADDRESS

24a. REC'D BY REGISTRAR DATE DEC 20 '61 — 24b. REGISTRAR'S SIGNATURE C. Harry S. Hanna

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14005

CERTIFICATE OF DEATH

13974

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Harford. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-White Hall
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old York Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-White Hall
d. STREET ADDRESS: Old York Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Geneva — Last: McCollough

4. DATE OF DEATH: Month: Dec. — Day: 12 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 28, 1874

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): White Hall, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: C. L. Almony

14. MOTHER'S MAIDEN NAME: Adalino Quigley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. Charles Ayres, White Hall Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arterio sclerotic Cardio Vascular disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19 to 12/12 ....., 1961, that (I) (we) last saw the deceased alive on 12/5 1961, and that death occured at 4:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. M. France — M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/14/61

22c. PHYSICIAN'S NAME (Type): A. M. FRANCE

22d. ADDRESS: PARKTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-15-61

23c. NAME OF CEMETERY OR CREMATORY: West Liberty Cem.

23d. LOCATION (City, town or county) (State): White Hall, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Jacob Hartenstein

ADDRESS: New Freedom, Pa.

25a. REC'D BY REGISTRAR: DATE DEC 18 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Krauss

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13975

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: RD 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print) First: DOA Middle: Gertrude Last: Mc Coy

4. **DATE OF DEATH**: Month: December Day: 17 Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-21-1883

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Reinke N. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Mc Coy

14. MOTHER'S MAIDEN NAME: Anna Dean Mc Coy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mrs Edgar A. Mull — Address: Bel Air, Md

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

Address (Street, city, town, or county): Bel Air Md.

DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/20/61

22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

22d. LOCATION (City, town, or country): Bel Air (State): Md.

23. FUNERAL DIRECTOR: Charles E. Hurtz

ADDRESS: Jarrettsville Md

24a. REC'D BY REGISTRAR DATE: DEC 21 '61

24b. REGISTRAR'S SIGNATURE: Clifton S Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14007

CERTIFICATE OF DEATH

13976

1. PLACE OF DEATH
a. COUNTY: Har Ford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
d. STREET ADDRESS: Rt#1, Box 10
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: LuTher Jeafferson — Middle: Mc — Last: GLothlin

4. DATE OF DEATH: Month: Dec. — Day: 2 — Year: 1961

5. SEX: MaLe

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 12, 1908

9. AGE (In years last birthday): 53 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mushroom Worker

10b. KIND OF BUSINESS OR INDUSTRY: Grower

11. BIRTHPLACE (County & State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John P. McGLothLin

14. MOTHER'S MAIDEN NAME: Mellie McGlothlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: 213-05-4365

17. INFORMANT: Carrie McGLoThLin (wife) — Address: Conowingo, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Perinephric abscess — 10 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8 ....., 1961, to 12/2 ....., 1961, that (I) (we) last saw the deceased alive on 12/2 ....., 19 61, and that death occured at 3P M, from the causes and on the date stated above.

22a. SIGNATURE (1) Neil R Taylor M D — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) Neil R Taylor

22d. ADDRESS: Rising Sun, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-6-1961

23c. NAME OF CEMETERY OR CREMATORY: Harmony Chapel

23d. LOCATION (City, town or county) (State): Liberty Grove, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vera Patterson & Son — ADDRESS: Perryville, Md

25a. REC'D BY REGISTRAR DATE: DEC 6 '61

25b. REGISTRAR'S SIGNATURE: Clifton S Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14008 Items 3 & 16 Film C302 12/11/61 ivk 13977

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace — c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, has dance before admission) a. STATE: Md — b. COUNTY: Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville

d. STREET ADDRESS: Box 372 — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: A (Mount) — Last: McKay

4. DATE OF DEATH: Month: 12 — Day: 3 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 20, 1926

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Otho Mount

14. MOTHER'S MAIDEN NAME: Mary Keesey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-18-5492

17. INFORMANT: Peter P. Mc Kay, Perryville, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): Chronic Nephritis — 7 yrs.

DUE TO (c): Terminal Pyelonephritis — 7 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Terminal Pyelonephritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1st 19 61 to Dec. 3rd 19 61, that (I) (we) last saw the deceased alive on Dec 3rd 19 61, and that death occured at 3:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [illegible] M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 12/4/61

22c. PHYSICIAN'S NAME (Type): [illegible] — 22d. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12-7-1961 — 23c. NAME OF CEMETERY OR CREMATORY: St Mark's Cemetery — 23d. LOCATION (City, town or county) (State): Perryville, Md. Rural

24. FUNERAL DIRECTOR'S SIGNATURE: Nell A. Patterson & Son — ADDRESS: Perryville, Md. — 25a. REC'D BY REGISTRAR DATE: DEC 6 '61 — 25b. REGISTRAR'S SIGNATURE: Elmer L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and ... director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9 6D

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G310 4/6/62 iwk

14684

1. PLACE OF DEATH
   a. COUNTY: Harford
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near Havre de Grace
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE #7

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   d. STREET ADDRESS: Route 7 Revolution Street extended
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert; Middle: Ross; Last: Mitchell

4. DATE OF DEATH: Month: 12; Day: 2; Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-27-1942

9. AGE (In years last birthday): 19 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Skyway Diner Food

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert O. Mitchell

14. MOTHER'S MAIDEN NAME: Lillie Louise Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO: No

17. INFORMANT (Name, address, and relationship, if any): Robert O. Mitchell P.O.Box 112 Havre de Grace Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

(a) IMMEDIATE CAUSE: Accidental-drowned in Chesapeake Bay near Havre de Grace, Maryland

DUE TO

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from Natural causes ☐. Accident ☒. Suicide ☐ Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: R.C. Dodson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: April 2, 1962

EXAMINER'S NAME (Type): R.C.Dodson

Address (Street, city, town, or county): Rising Sun, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-3-1962

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or country) (State): Havre de Grace, Harford Co., Md.

23. FUNERAL DIRECTOR: R. Madison Mitchell

ADDRESS: R. Madison Mitchell Havre de Grace Maryland

24a. REC'D BY REGISTRAR DATE: APR 4 '62

24b. REGISTRAR'S SIGNATURE: Cinthia S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14009 · 13978

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE: Md b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: Blenheim RD1 Box 53
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Elizabeth Middle F. Last Osborn
4. DATE OF DEATH: Month 12 Day 12 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 2nd 1882
9. AGE (In years last birthday): 79 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Never Worked
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Henry Osborn
14. MOTHER'S MAIDEN NAME: Frances Fletcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Inez L. Osborn - Havre de Grace # 1 - Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Chronic Cardiac Decompensation	7 years.
DUE TO (b)	Arteriosclerotic Cardiovascular	10 years.
DUE TO (c)	Disease.	

422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 6th, 1961 to Dec. 12th, 1961 that (I) (we) last saw the deceased alive on Dec. 12th, 1961 and that death occurred at 0P M. from the causes and on the date stated above

22a. SIGNATURE: Edward C. Loo M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 12/12/61
22c. PHYS CIAN S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BUR AL, CREMATION REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/15/1961
23c. NAME OF CEMETERY OR CREMATORY: Grove Presbyterian
23d. LOCATION (City, town, or county) (State): aberdeen maryland.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John G. Tarring - aberdeen. md.
25a. REC D BY REGISTRAR DATE DEC 21 '61
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with[illegible] hours after death. Page 4 [illegible] retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14010 13979

1 PLACE OF DEATH a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE: Md. b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN 1b: 22 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bel Air

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

d. STREET ADDRESS: RFD 2 Churchville Rd.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Zula Middle: Elizabeth Last: Peters

4. DATE OF DEATH: Month: Dec. Day: 18 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 15, 1881

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): U.S.A - Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George Thomas

14. MOTHER'S MAIDEN NAME: Betty Reid

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT (Son): Mr Henry M. Peters — Address: 129 N. Lynbrook Road. Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cardiac Arrest. — INTERVAL BETWEEN ONSET AND DEATH

450.0

DUE TO (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 8 1961 to Dec 18 1961 that (I) (we) last saw the deceased alive on 12-18 1961, and that death occurred at 3P M, from the causes and on the date stated above

22a SIGNATURE: Frank D. Hawker M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 20, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery

23d. LOCATION (City, town, or county) (State): Rural Bel Air, Harf. Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway and Williams St. Bel Air, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 21 '61

25b. REGISTRAR'S SIGNATURE: Clifton L. Evans

Joseph W. Foster

FOSTER FUNERAL HOME W. BROADWAY & WILLIAMS BEL AIR, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A3 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14011 — 13980

1. PLACE OF DEATH
a. COUNTY: Harford — STATE: Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 72 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 401 S. Washington
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Murray — Last: Poplar

4. DATE OF DEATH: Month: 12 — Day: 10 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1/10/1889

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Penn. Railroad

11. BIRTHPLACE (County & State, or foreign country): Havre de Grace, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. H. Poplar

14. MOTHER'S MAIDEN NAME: Annie Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) If yes, give war or dates of service: Unknown

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Violet N. Poplar 401 S. Washington Havre de Grace, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 422.1
DUE TO (b): Cardio-Vascular Heard Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — a.m. ☐ p.m. ☐ — Month, Day, Year: — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May, 19 60 to 12-9, 19 61, that (I) (we) last saw the deceased alive on 12-4 19 61, and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Gunther D. Hirsch M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-11-61

22c. PHYSICIAN'S NAME (Type): GUNTHER D. HIRSCH

22d. ADDRESS: 421 CONGRESS AV. HAVRE DE GRACE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/12/61

23c. NAME OF CEMETERY OR CREMATORY: Angel Hill

23d. LOCATION (City, town or county) (State): Havre de Grace, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington Son

ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 14 '61

25b. REGISTRAR'S SIGNATURE: Herbert L. Fisher

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14012

Reg. Dist. No. 13981

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 14 yrs.,
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: East Ring Factory Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: W.; Last: Possehl

4. DATE OF DEATH: Month: Dec.; Day: 5; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Apr. 25, 1866

9. AGE (In years last birthday): 95 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,

11. BIRTHPLACE (State or foreign country): London, England.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: August Possehl

14. MOTHER'S MAIDEN NAME: - Wilkinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 198-05-0520 A

17. INFORMANT: Mrs. Edward H. Kerns, Address: Bel Air Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 Days
DUE TO (b): Cerebral arteriosclerosis — ? ?
DUE TO (c): Generalized arteriosclerosis - — ? ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 1, 1961, to Dec. 5, 1961, that I last saw the deceased alive on Dec 4, 1961, and that death occurred at 2 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles Richardson M.D. ADDRESS (Street, city or town, state): 1265 Main DATE SIGNED: Dec 5 1961

PHYSICIAN'S NAME (Type): Charles Richardson, Jr., Bel Air Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 7, 1961

22c. NAME OF CEMETERY OR CREMATORY: Hillside

22d. LOCATION (City, town, or county) (State): (Roslyn) Philadelphia, Pa.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howrad K. Mc Comas & Son Howard K. McComas Jr.
ADDRESS: Abingdon, Md.,

24a. REC'D BY REGISTRAR DATE: DEC 7 '61

24b. REGISTRAR'S SIGNATURE: Curtis L. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14013

CERTIFICATE OF DEATH

13982

1. **PLACE OF DEATH**
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 28 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL Hosp.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo (Rural)
d. STREET ADDRESS: Pilot Town Rd - Rt. 222
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillie — Middle: MAE — Last: Ritchie

4. DATE OF DEATH: Month: DECEMBER — Day: 6 — Year: 1961

5. SEX: FEMALE — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 12-10-1895 — 9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: own Home — BIRTHPLACE (County & State, or foreign country): MARYLAND — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John McCullough — 14. MOTHER'S MAIDEN NAME: Lydia Dunn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT: Mr. G. Cleveland Ritchie — Address: Conowingo, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic Failure - Post Oper — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cirrhosis of liver

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): S&I, C

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..., to ....., 19....., that (I) (we) last saw the deceased alive on ..... 19, and that death occured at 6.15 A M, from the causes and on the date stated above.

22a. SIGNATURE: Wm. K Brenden M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: Dec 6, 61

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12-9-1961 — 23c. NAME OF CEMETERY OR CREMATORY: Brookview Cem. — 23d. LOCATION (City, town or county): Rising Sun — (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Vernon E. McMullen — ADDRESS: Rising Sun, Md.

25a. REC'D BY REGISTRAR DATE: DEC 11 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur E. Krauss

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14014 — 13983

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 152 Bloomsbury Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Wood — Last: Sampson

4. DATE OF DEATH: Month: DECEMBER — Day: 8 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 13, 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRANK S. SAMPSON

14. MOTHER'S MAIDEN NAME: MAGGIE McCALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: Mrs. Marguerite H. Sampson — Havre de Grace MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 422.2 — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Cardiac Insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic Myocarditis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-24 19 61 to Dec. 8 1961, that (I) (we) last saw the deceased alive on 12-8 19 61, and that death occured at 6:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Havre de Grace MD — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Havre de Grace MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: DEC. 10 1961

23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEM.

23d. LOCATION (City, town or county) (State): HAVRE DeGRACE MD

24 FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REGISTRAR DEC 12 61 — DATE DEC 12 1961

25b. REGISTRAR'S SIGNATURE: Chas. S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14015

CERTIFICATE OF DEATH

13984

M

I

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haure de Grace, Md

c. LENGTH OF STAY IN 1b: 5 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Haure de Grace, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md — b. COUNTY: HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen

d. STREET ADDRESS: General Delivery

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: John — Middle: Henry — Last: Singleton

4. DATE OF DEATH Month: December — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 4, 1880

9. AGE (In years last birthday): 81 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: XXXXXXXXXXXX James Singleton

14. MOTHER'S MAIDEN NAME: Mary Sampson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-18-7990

17. INFORMANT — Address: Lillie Singleton, Aberdeen, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Thrombotic occlusion ant. desc. coronary artery — INTERVAL BETWEEN ONSET AND DEATH: Terminal

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — 10 yr.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastric ulcer with massive haemorrhage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 29 1961 to ~~Nov 29~~ Dec 3 1961, that (I) (we) last saw the deceased alive on Dec. 3 1961, and that death occurred at 12:05 P M, from the causes and on the date stated above. P.P.R.

22a SIGNATURE: Peter P. Rodman M.D. — M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-4-61

22c PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.

22d. ADDRESS: Aberdeen, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 12/6/61

23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,

23d LOCATION (City, town, or county) (State): Aberdeen, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John G. Tarring — John G. Tarring

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: DEC 6 '61

25b. REGISTRAR'S SIGNATURE: [illegible] S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4

VR A15 (4) 15M 9/59

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14015

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOSTER FUNERAL HOME
W. BROADWAY
BEL AIR, MD.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Bel Air — c. LENGTH OF STAY IN 1b: 50 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): XRural-Bel Air
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Forge Hill Road	d. STREET ADDRESS: Forge Hill Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Mary	A.	Smith	December	29,	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	C		May 30, 1879	82 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Housework	Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harrison Preston	Mary Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Son)	Address
No ----	213-20-2717	Mr. L. Gerald Smith	RFD#1, Box 153 Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Metastatic Carcinoma	1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Carcinoma of Cervix	4 months
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malnutrition; Arteriosclerotic Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 28, 1961, to December 29, 1961, that I last saw the deceased alive on December 28, 1961, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul S. Stonesifer Jr. M.D.

ADDRESS (Street, city or town, state): DATE SIGNED

PHYSICIAN'S NAME (Type): PAUL S. STONESIFER JR. 115 FULFORD Ave, BEL AIR, MD. 12/30/61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan. 2, 1962	St. Ignatius Cem.	Hickory, Harford Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
Joseph W. Foster	W. Broadway & Williams' Bel Air, Maryland	JAN 2 '62	C. Lee Jr. Travers

Joseph W. Foster

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14017

CERTIFICATE OF DEATH

13986

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 37 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 251 Lewis St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Myrtle Middle: Elizabeth Last: Smith

4. DATE OF DEATH: December 5 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 23, 1897

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alonzo Bond

14. MOTHER'S MAIDEN NAME: Provey Banks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 213-30-6936

17. INFORMANT: Mr. James K. Holland Address: 251 Lewis St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Abdominal Carcinomatosis

DUE TO (b): Adenocarcinoma of the Colon

DUE TO (c):

153.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Not Known

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/30/1961, to 12/5/1961, that (I) (we) last saw the deceased alive on Dec 5 1961, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. H. Sadowsky M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 12/5/61

22c. PHYSICIAN'S NAME (Type): W. H. SADOWSKY MD

22d. ADDRESS: 504 Lewis St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-9-61

23c. NAME OF CEMETERY OR CREMATORY: Asbury Methodist Cem.

23d. LOCATION (City, town, or county) (State): Churchville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Otelia J. Bullock ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 7 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14018

CERTIFICATE OF DEATH

Reg. Dist. No. 13387

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): STREET
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X STREET
d. STREET ADDRESS: JERRY ROAD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MARY Middle VIRGINIA Last SMITHSON

4. DATE OF DEATH: Month December Day 3 Year 19 61

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: November 1, 1960

9. AGE (In years last birthday): 1 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Lee Smithson

14. MOTHER'S MAIDEN NAME: Mabel Marie Hopkins

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): --
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO: ---

17. INFORMANT: William Lee Smithson — Address: Jerry Rd., Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Laryngotracheobronchitis and bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
501 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): obesity

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from December 2, 1961, to December 3, 1961, that I last saw the deceased alive on December 3, 1961, and that death occurred at 10:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul S. Stonesifer Jr. M.D.
ADDRESS (Street, city or town, state): 115 Fulford Ave. Bel Air, Md.
DATE SIGNED: 12/3/61
PHYSICIAN'S NAME (Type): PAUL S. STONESIFER, JR., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 5, 1961
22c. NAME OF CEMETERY OR CREMATORY: Slate Ridge
22d. LOCATION (City, town, or county) (State): Delta, Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Hawkins
ADDRESS: Delta, Pa.

24a. REC'D BY REGISTRAR DATE: DEC 5 '61
24b. REGISTRAR'S SIGNATURE: Clinton L. Hiaus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14019

CERTIFICATE OF DEATH

13988

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 45 mos
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Aberdeen
d. STREET ADDRESS: Paradise Rd RD2 Box 34
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: Stephens

4. DATE OF DEATH: Month: 12 — Day: 11 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 9/15/1876

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR / IF UNDER 24 HRS — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary/Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeremiah S. Stephens

14. MOTHER'S MAIDEN NAME: Mary E. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: William M. Stephens — Address: 553 Bourbon St. Havre de Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Immed

DUE TO (b): Hypertensive cardiovascular disease — 10 yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 44 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 12 1957 to Dec 11 1961, that (I) (we) last saw the deceased alive on Dec 11 1961, and that death occurred at 7:30 M. from the causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips III M D

ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dudley Phillips III

22d. ADDRESS: Darlington Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/14/1961

23c. NAME OF CEMETERY OR CREMATORY: Harmony Presbyterian

23d. LOCATION (City, town, or county) (State): Darlington, Rural, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John E. Darring — ADDRESS: Aberdeen Md

25a. REC'D BY REGISTRAR DATE: DEC 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13989

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Abingdon~~ Edgewood
d. STREET ADDRESS: 1 S R B 16
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): ~~HARRY~~ First — FRANKLIN Middle — STOTLER Last
4. DATE OF DEATH: Month — December; Day — 21; Year — 1961

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	MARRIED ☒	Oct. 15, 1914	47 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Electrician	Shoe	Berkley Springs, W.Va.,	U.S.A.,

13. FATHER'S NAME: Thomas Stotler
14. MOTHER'S MAIDEN NAME: Icy Vanorsdale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	705-10-7206	Lelia A. Stotler	Edgewood R.D., Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture skull — INTERVAL BETWEEN ONSET AND DEATH

V 825X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Auto accident
20c. TIME OF INJURY Hour a.m. / p.m. — Month, Day, Year: 12-21-1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Edgewood (County) Ha (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Harold C Palmer M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Harold C Palmer M.D.
Address (Street, city, town, or county): Bel Air, Md.
DATE SIGNED: 12-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	Dec. 24, 1961	Cokesbury Memorial	Abingdon, Harford, Maryland

23. FUNERAL DIRECTOR: Howard K. Mc Comas & Son — ADDRESS: Abingdon Maryland
Howard K. McComas Jr

24a. REC'D BY REGISTRAR — DATE DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Clarence L. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14021

13990

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours. Page 1 must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the cause of death completed, it should be detached for use as the burial-transit permit.

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
   c. LENGTH OF STAY IN 1b: 1 day
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial

2. **USUAL RESIDENCE** (Where deceased lived, If institution: residence before admission)
   a. STATE: Md
   b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Belair Md
   d. STREET ADDRESS: 211 N. Main St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Sarah — Middle: Gale — Last: Woodruff

4. **DATE OF DEATH**: Month: 12 — Day: 18 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 18-1938

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months: — Days: —

IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard Woodruff

14. MOTHER'S MAIDEN NAME: [illegible] Middleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs Robert Mitchell — Box 302 R Aberdeen #2 Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic Acidosis
DUE TO (b): Diabetes Mellitus
DUE TO (c):

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 days. 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, ~~NOTIFY~~ MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ ~~Not While at work~~ ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Dec 18th., 1961, to Dec 18th, 1961 that (I) (we) last saw the deceased alive on Dec 18th 1961, and that death occured at 1.0 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Coon, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec 18th 61

22c. PHYSICIAN'S NAME (Type): Edward C. Coo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/21/1961

23c. NAME OF CEMETERY OR CREMATORY: Harmony Presbyterian

23d. LOCATION (City, town or county) (State): Darlington, Harford Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: John F. Darring — ADDRESS: Aberdeen, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

YR A15 (4) 15M 9/60